

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 03-34	2. STATE Louisiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE September 12, 2003	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

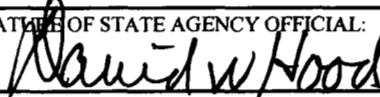
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.170	7. FEDERAL BUDGET IMPACT: a. FFY <u>2003</u> \$0.00 b. FFY <u>2004</u> \$0.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Item 24.a., Page 3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same (TN 03-29 Proposed)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to amend the Medicaid State Plan to indicate that friends and family providers shall continue to be reimbursed at the rates in effect on July 31, 2003.**

11. GOVERNOR'S REVIEW (Check One):

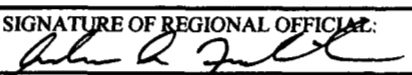
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☒ OTHER, AS SPECIFIED: **The Governor does not review state plan material**☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030
13. TYPED NAME: David W. Hood	
14. TITLE: Secretary	
15. DATE SUBMITTED: September 24, 2003	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 29 SEPTEMBER 2003	18. DATE APPROVED: 17 DECEMBER 2003
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 12 SEPTEMBER 2003	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: ANDREW A. FREDRICKSON	22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

Attachment 4.19-B
Item 24.a. Page 3

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION

42 CFR
440.170

Medical and
Remedial Care
and Services
Item 24.a
(cont'd.)

b. Family and Friend Providers

Effective on September 12, 2003, non-emergency medical transportation provided by friends and family will be reimbursed at one half of the for profit rate in effect July 31, 2003.

c. Non-Profit Providers

For round trips up to 65 miles, providers are reimbursed at the for-profit rate reduced by \$3. For each 30 mile increment over 65 miles, the rate is increased by \$7.50 per increment.

Effective for dates of services on or after August 1, 2003, Local Nonprofit – Wheelchair and Nonprofit – Local Trip will be increased by 20 percent of the rate in effect on July 31, 2003.

d. Aircraft and Buses

Medically necessary non-emergency transportation provided by commercial aircraft and buses are reimbursed at their usual and customary rate, subject to maximum limitations based on historical costs for such trips.

e. Ambulances

Medically necessary non-emergency ambulance transportation services are reimbursed at rates negotiated between participating providers and the Bureau of Health Services Financing minus the amount which any third party would pay for that provider.

SUPERSEDES TN 03-29

STATE	<u>Louisiana</u>	A
DATE RECEIVED	<u>9-29-03</u>	
DATE APPROVED	<u>12-17-03</u>	
DATE OF EFFECT	<u>9-12-03</u>	
HCFA 179	<u>03-34</u>	

TN# 03-34

Approval Date 12-17-03

Effective Date 9-12-03

Supersedes

TN# 03-29